Universalism and Private Funding : The French Model of Universal Medical Coverage

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Abstract : In France, a law passed in 1999 modernized and unified the various forms of medical assistance for the poor. This law provides free affiliation to the statutory health insurance scheme as well as free or subsidized affiliation to a complementary health insurance scheme. People with little or no income thus have access to free medical care. The new scheme binds together what the theoretical literature on healthcare systems considers to be contrasting components: universalism, choice, and income thresholds. The particular French arrangement results from a compromise between two general policy streams: poverty relief, and control of public spending. The result is a unified public safety net for healthcare, financed by the private complementary health insurance funds, via a specific tax. This article first maps out the institutional context and related theoretical debates. The second part then analyses the policy making process, and presents the organization of the universal medical benefits system (*CMU - Couverture Maladie Universelle*). The third part focuses on the beneficiaries, the financing and the expenditure. The fourth and final part assesses the outcomes in terms of success and failure: a substantial improvement of the medical safety net, albeit with rather low thresholds; broad political consensus supporting the legislation, though ongoing controversy over the benefits granted to undocumented migrants; and institutional normalization that promotes social assistance to the status of a legal right.

Keywords : health safety net, universal health coverage, Couverture Maladie Universelle (CMU), undocumented migrants, France

I Institutional architecture and intellectual controversy

The French social security system provides medical coverage through a statutory health insurance scheme for the entire population (66 million inhabitants). This scheme comprises three distinct regimes: the *Régime Général* for salaried workers, the *Régime des Indépendants* for self-employed workers and professionals, and the *Mutualité Sociale Agricole* for farmers and agricultural workers. In addition to these employment-based systems, two specific regimes exist for people outside the labor market, and who are not co-insured as family members. Universal access to healthcare is organized through the combination of five distinctive levels:

1. **Compulsory health insurance** (*Assurance Maladie*, hereafter referred to as **AM**). The founding principles are those of a Bismarckian social health insurance, based on professional status and work-

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related income. The AM is co-financed by a payroll-based contribution from employers, and, since 1996, by an earmarked tax on the members' entire income[1].

2. **Voluntary complementary health insurance** (*Assurance Maladie Complémentaire*, hereafter referred to as **AMC**), operated by private organizations, which covers a large percentage of members' health expenses that are not reimbursed by the statutory health insurance: approximately 25%. Nearly the entire population (96%[2]) is affiliated to this type of AMC scheme. The high prevalence of AMC has a positive solidarity effect: it spreads the remaining costs over the entire population of AMC affiliates, which avoids the concentration of out-of-pocket payments on individual patients. Two-thirds of the AMC market is held by not-for-profit organizations. Many of them still operate with the traditional income-based premiums, although they are now adjusting for age and number of co-insured family members, as for-profit complementary health insurers do. Only such limited risk selection is permitted in France.
3. **The list of serious and long-term illnesses** (*Affection de Longue Durée*: **ALD**) defines thirty-three categories of pathology, comprising more than 400 illnesses, for which the AM reimbursement amounts to 100%. Access to this regime depends mainly on a medical decision, and doctors have often used the ALD arrangement to obtain full reimbursement for their patients[3]. The rapid growth in the number of ALD beneficiaries reflects of course the growing impact of chronic disease, but it also indicates a need for a stronger medial safety net[4].
4. **Universal medical coverage** (*Couverture Médicale Universelle:* **CMU**[5]) has been in operation since 2000. It was instituted by law in order to provide a unified safety net for those who are not covered by the AM and/or do not have the means to afford an AMC. The scheme comprises three layers, all subject to means testing: first, the "basic" CMU (hereafter referred to as the CMU-B), which provides access to the AM for people residing in France, who cannot be affiliated otherwise. If their income is below a threshold, they are affiliated free of charge. Second, the "Complementary" CMU (hereafter referred to as the CMU-C), which provides free affiliation to an AMC. Third, a cash benefit, the ACS (*Aide au paiement d'une Complémentaire Santé*), which is financial assistance for access to complementary health insurance. A "health voucher" is given to people whose income is low but exceeds the CMU threshold, in order to help them pay for their own complementary health insurance.
5. **State medical assistance** (*Aide Médicale d'État:* **AME**). Since undocumented migrants cannot benefit from the CMU, which is based on official residence in France, this specific regime was added to the CMU legislation. It serves anyone with administrative difficulties and needing medical care. The care basket is the same as for CMU patients.

One more regime should be mentioned here: humanitarian medical assistance. This purely private and very militant assistance focuses on particular groups to which the official institutions cannot reach out, or do so only with difficulty and poor results. The humanitarian organizations can receive public subsidies[6] or act as service providers, negotiating their programs with local or central government, including the AM. They act as "fire fighters" in extremely marginalized populations or situations with public health risks (the homeless, isolated mentally ill individuals, people living underground, such as heavy drug addicts, migrants fearing expulsion, Roma communities, etc). Their work consists mainly in community organizing, and in offering the first point of contact for individuals in need. They provide translation and counseling, resolve administrative problems and guide patients to join the CMU and AME. Their action constitutes a necessary complement to the statutory regimes, for information and counseling, and thus acts as a form of "delegation of public services" (Maury, 2013).

This article will focus on the CMU regime and its by-product, the State medical assistance (AME)[7]. It will examine how and to what extent these arrangements fulfil their mission of providing an effective medical safety net to the populations in need.

The CMU legislation was passed in 1999 with a broad political consensus among all major political parties, from the Left to the Right. Intellectuals however engaged in controversy underpinned by theoretical debates about the legitimate foundations of the new CMU arrangement, as well as its articulation with the principles of social security and the "normal" health insurance system.

The links between a social health insurance based on entitlement, on the one hand, and safety-net arrangements with income thresholds, on the other, do indeed constitute a challenging theoretical issue, because of the national differences in institutional frameworks and the political meanings they convey. The interesting question here is: to what extent are the concepts and theories of general significance, or limited to national and historical boundaries?

French intellectual debates in this respect can be summarized under three headings[8]. The first point concerns the links between social *security* and social *assistance* (Borgetto, Chauvière et Frotiée 2004; Chauchard et Marié, 2001; Desprès 2010; Lafore 2010): are they contradictory or complementary? Several authors see the CMU as a watershed in the history of the French social security system, a reform that "severs the relationship between citizenship and professional activity" (Frotiée, 2006: 12). However, as many have pointed out, this evolution was already initiated before the CMU, in 1988, when all beneficiaries of the minimum income support scheme were affiliated to the AM, automatically and free of charge. Others argue that the CMU is simply another step in the generalization of social security and AM coverage (Chauchard et Romain 2001). Lafore and Borgetto (2000) discuss the role of social assistance in the *"République sociale",* in particular in connection with democracy, law and the reciprocity of duties. In this article it will be argued that the CMU safety net is a pragmatic adaptation to new socioeconomic realities: an incremental process of modernization aimed at updating previously existing arrangements.

The second point of theoretical discussion concerns the *concept of universalism,* in relation to equity, equal chances, and the fight against poverty (Borgetto, 2000). In French, the term universalism commonly conveys contradictory meanings: on the one hand, it is understood as equal treatment, rejecting targeted schemes and policies; on the other, it refers to "access for all", a goal which often calls for targeted actions in order to reach out to those in special need. In this context, analysts of the CMU often point out that the French health insurance does not reimburse the full expenditure, which obviously constitutes a handicap for achieving universalism, and furthermore that universalism can only be based on residency, not on a Bismarckian-type of social health insurance. These arguments would suggest that the French healthcare system could not achieve universal coverage, because of the Bismarckian structure linked to employment, as well as the important role of private providers and doctors who overcharge, on the one hand, and the refusal in public opinion as well as in the policy networks to adopt a British-type of National Health Service, on the other hand. However, in empirical terms and by international comparison[9], medical coverage in France stands out for its high level. As the statistics below show, the CMU has contributed to further improving access.

The third point of the controversy theorizes a longstanding political debate opposing the social security institutions, conceived for and financed by the working population, on the one hand, to the tasks of *"national solidarity"* considered as being the responsibility of the national government, on the other. From the latter point of view, healthcare for targeted populations such as CMU beneficiaries should rely exclusively on "national solidarity" and be financed from general taxes. This perspective would however demand new organizational frameworks and could lead to a separate "public" distribution of medical care for the poor, e.g. a "two-tiered" healthcare system – an option that is not supported in France by politicians or public opinion. In empirical terms the question relates to organizational problems: which institution should be in charge of the management of the healthcare safety net and who should pay for it?

These debates need to be linked to the particularities of the French healthcare system, which does not easily fit the common categories used in international comparison. The French system has been described in various and contradictory terms: as half way between the Bismarckian and the Beveridgian models (Hassenteufel 2001), as mainly a "public-private mix" (Godt 1991); as a "neo-Bismarckian regulatory healthcare state" (Hassenteufel and Palier, 2007); and as a system under direct government control (Rochaix and Wildford), with few veto points (Immergut, 1992).

To understand the articulation between the statutory AM and the medical assistance regime, one needs to focus on the relationship between the state, local authorities, and the social health insurance. In this perspective, the French healthcare system resembles a "Statist model of Social Health Insurance" (Matsuda and Steffen, 2013; Steffen 2010b). Furthermore, one needs to consider the important role that the private sector plays in the system. Its unique combination of universal access, free choice for the patients, private doctors and complementary health insurances, has been conceptualized as "Liberal Universalism" (Steffen 2010a). Given this context, three key questions need to be answered:

- How is the residence-based safety net combined with the social health insurance?
- How is the safety net articulated with private providers of care and insurance?
- How is care and administration organized for non-registered residents?

In other words: Who pays for the care for the non-contributing population? What is the care basket for them? Who decides on these matters and how?

Table 1: Healthcare financing, 2013

Expenditure for Medical Consumption	**Share in %**	**Origin of funding**
Social health insurance	**76.0**	Compulsory contribution
State (for CMU and AME)	**1.4**	"Public" (in principle)
Complementary mutual health insurance	**7.3**	Private premium, to not-for-profit organizations
Complementary commercial health insurance	**3.9**	Idem, for profit
Complementary health insurance within contingency funds	**2.6**	Idem, partly not-for-profit
Out of pocket	**8.8**	Private individuals
187 billion Euros (8.8% of GDP)[10]	**100%**	**€2,843 per capita/annum**

Source: Zaidman et al. (2014: 19, 69–84)

II Social Inclusion: Modernizing, Harmonizing, Centralizing

The law instituting the CMU and the AME, passed on 27 July 1999 and applied on 1 January 2000, did not start from scratch. It replaced the previous medical safety net operated under a law dating all the way back to 1893[11], which obliged local public authorities (municipalities, *Départements*) to provide medical care for the "poor" of their territory. The system was essentially discretionary, without any national rules or guidelines being defined. Once a request for medical assistance had been approved by the local mayor or commission, the administration issued a document that the patient would give to the doctor, who would be paid directly by the local authority according to locally set rates. The system suffered from the medical profession's reluctance to cooperate and from different conditions for access and benefits across the country. There was need for reform and unified rights, especially as the labor market was changing and unemployment growing. The 1999 law transferred the responsibility for income testing[12] from local politicians and social services to the local funds of the statutory AM. It set up standardized national income thresholds, varying only according to the size of the household, and fixed the list of benefits valid throughout the country. Free care thus became a right, and no longer assistance depending on the good will of local politicians.

The CMU replaced not only the former local medical assistance scheme, but also "personal affiliation" to the health insurance scheme. The latter type of affiliation had been created in the early 1980s for people who did not qualify for compulsory affiliation to the AM through employment. But as the personal premiums were very high, people tried to escape from this affiliation, which became a source of cheating. Former "personal" affiliates whose income is below the CMU threshold are now entitled to free affiliation. Furthermore, the CMU legislation constituted a political alternative to a more general reform planned in 1995 by former Prime Minister Alain Juppé (from the right wing), for a "universal health insurance", whose project was fiercely and successfully fought by the (socialist) opposition and the trade unions.

The 1999 CMU law included a provision for undocumented residents and immigrants, who were excluded from the residence-based CMU scheme. Since the local medical assistance scheme had been abolished, undocumented migrants would be deprived of any access to medical care. The law therefore included a specific safety net, the *Aide Médicale d'État (AME),* mainly for illegal foreigners, but it serves for any other person with administrative difficulties.

The CMU legislation was successfully adopted and implemented, because it was part of a more general policy stream aimed at poverty alleviation. It enjoyed broad support from public opinion, in sharp contrast to the rejected Juppé plan. The CMU legislation also had an important forerunner: the automatic affiliation to the AM, free of charge, for all beneficiaries of the "Minimum Income support" instituted in 1988 by the (socialist) Prime Minister Michel Rocard. In 1998, when the socialists returned to power, a further law was adopted to improve "access to all fundamental rights" for people with low incomes. The barriers to access to medical care are well known and regularly mentioned in reports: incomplete reimbursement and the necessity to pay for a AMC, the reimbursement system that obliges patients to first advance costs, and the possibility for many doctors to overcharge. Policy-making for the safety net was fuelled by strong mobilization by humanitarian organizations working at the front line of public health issues in marginalized populations. Well trained in mobilization, political lobbying and fund raising, these organizations argued that

a medical safety net had become a "social urgency". They were listened to in the senior administration of the health ministry, and actually participated in drafting the bill (Frotiée 2004).

The failure of the Juppé plan for a universal health insurance scheme, and the success of the CMU and its particular organizational arrangements which will be analyzed below, illustrate the difficulty of carrying out structural reforms in the healthcare sector, and the importance of incremental change building on existing institutions and inherited ideas and beliefs. The success of the new legislation was achieved through three practical measures: effective response to identified needs, clear common rules, and administrative simplification through a single reception desk.

The CMU-B provides free affiliation to the AM for small income earners. In addition to this, the CMU-C offers free affiliation to an AMC. Both these parts of the CMU operate on the basis of official residence in the country and income testing[13]. Healthcare for beneficiaries is paid directly to the providers, without the patient having to advance money or to pay the out-of-pocket lump sums usually required. In addition to this advantage, medically prescribed items that are normally not reimbursed or only at a symbolic rate (e.g. spectacles, dental prostheses, hearing devices and other equipment), are provided free of charge to CMU patients, within price limits allowing for average quality standards. CMU and AME beneficiaries thus have a more extended cover for most medical needs than the contributing affiliates to the AM.

Residents whose income is slightly above the CMU threshold receive a "health voucher" (known as *Aide pour l'acquisition d'une Complémentaire Santé, ACS*) to help them to subscribe to a private AMC.

Applications for the different layers of the safety net – CMU, AME, and ACS – are all to be submitted to and treated by the same local office of the AM. This single reception desk checks the documents, especially the applicant's income, organizes the payment of the ACS-health voucher, and issues the CMU or AME electronic health cards. These procedures need to be renewed annually. Family members are affiliated according to the same rules as those governing the statutory AM.

For the CMU and ACS, the only documents required are proof of identity, residence (such as electricity bills or rent payments) and income (tax notification, social allowances, etc.[14]). For the AME, the requirement is proof of foreign nationality and of presence in the country for at least three months but for less than a year[15] (hotel bills, witness testimonials).

Two types of controversy accompanied the implementation of the CMU safety net.

The first concerned the income thresholds, criticized as being too low. Critics pointed in particular to the fact that people with income just above the thresholds would be excluded from the benefits of the CMU although their income would not be sufficient to pay for an AMC. The decision makers in the ministry responded in the following way: thresholds needed to be fixed with regard to other social minima and thresholds (minimum income, old-age social assistance, etc.), and to remain below them for reasons pertaining to public spending. This was seen as being socially acceptable since not benefitting from a free AMC was less dramatic than losing the monetary allocation for everyday living costs. Illness was not considered to be a permanent risk (CMU Fonds 2001: 3).

Table 2: Income Thresholds in 2013 (Mainland France)

Household members	CMU and AME in Euros		ACS ("Health Voucher") in Euros	
	Per Year	Per month	Per year	Per month
1	8,645	720	11,670	977
2	12,967	1,081	17,505	1,459
3	15,560	1,297	21,006	1,751
4	18,153	1,513	24,507	2,042
5	21,611	1,801	29,175	2,431
Additional person	+ 3,457	+ 288	+ 4,668	+389
Thresholds for the French Oversee Territories are 12% higher				

Adjustments have however been introduced. Article 23 of the CMU law already obliges the AMC to keep any former CMU-C beneficiary at the same premium for at least another year after they have ceased to be eligible for the CMU scheme. During the year 2000, the government allocated a special public grant of €400,000 to the statutory health insurance in order to "help people at the CMU borderlines" (CMU-Fonds, Report 2001: 3). Local AM funds took various measures to soften the borderlines. It became general practice in the AM funds to accept candidates with income up to 10% above the threshold. The ministry then centralized these various initiatives, and added corresponding paragraphs to the law. In 2000, the principle was thus legalized that up to 10% above the threshold, people could still benefit from the third-party-payer system, e.g. without having to advance money for care. The provision was later extended to one more year of membership of the CMU system after exceeding the income threshold (unless the person entered employment and could be insured under the regular compulsory system).

The most important adjustment was made by a law enacted on 13 August 2004, which introduced the ACS (health voucher) arrangement, applicable from 1 January 2005. This subsidy is given to all people with income above the CMU threshold, fixed initially at 20% above[16], then extended to 35% in 2013[17], in order to help them pay for their own AMC. The level of the ACS-subsidy varies with the age of the individual household members: for 2014, per year and person, it amounted to €100 for household members under the age of 16, €200 for 16–49 year-olds, and €550 for those over 60. This public subsidy may favor the commercial AMC market, with risk-adapted premiums, but most of the beneficiaries (84.7%) opt for the statutory health insurance as their complementary AM (CMU Fonds, 2013b: 36–37). CMU beneficiaries are the *only* persons for whom the public AM acts also as AMC. This particular provision may prefigure a future evolution of the French health insurance towards a catalogue of options in the health coverage, similar to those in the Netherlands and Germany.

The thresholds for the ACS "health voucher" benefit have been fixed at 60% of the net median income, which corresponds to the poverty line. The latter is situated at €977 per month for a single person (CMU Fonds, 2013b: 18). All together, the CMU and ACS thresholds remain low, which keeps the number of beneficiaries within limits. Thresholds had not been updated for years, when President François Hollande (socialist) decided on a general upgrading of 8.3% from 1 July 2013. A further increase is planned but may not be implemented, given the high level of public debt.

The second controversy concerned the articulation of statutory and complementary health insurance. To understand this particular French problem we need to bear in mind the following:

- The CMU-C arrangement is a necessary complement since the statutory AM reimburses only approximately 75% of medical costs, which applies also to the CMU-B.
- Most CMU beneficiaries choose the statutory AM as their point of affiliation for their CMU-C, despite the existence of the private AMCs.

An important ideological element in the French healthcare system is "free choice". When the CMU law was in preparation, the humanitarian non-profit associations insisted strongly on the principle of future beneficiaries having "free choice" concerning the organization to which they would like to be affiliated for their CMU-C coverage. The aim was to "prevent stigmatization" that could arise from specific public care pathways for CMU patients. Senior government officials in charge of drafting the legislation were sensitive to this "normalization" argument. Consequently, at the time of admission to the CMU-C scheme, beneficiaries have to choose whether they want to use the statutory AM as their AMC, or be affiliated to a private AMC and, if so, to indicate which one.

The issue became a tricky financial problem once the system was operating, because the public funding allocated by the government to the institutions affiliating the beneficiaries follows the beneficiary's choice. Initially, the public AM funds were reimbursed for their CMU expenditure at the real cost, whilst private AMCs received a fixed per capita sum, and had to support the financial risk themselves. Senior officials in the social security department of the ministry in charge of health promoted this option with a twofold argument: on the one hand that a safety net was a "national solidarity" mission and therefore to be financed by public authority and general taxes, but on the other hand that, as the beneficiaries would also be "clients" for the private AMCs, the government needed to pay only for the "affiliation", not for the actual medical charges the affiliated CMU beneficiaries would incur. Opinions evolved when the 2004 law was drafted, to reform the health insurance in a more managerial sense. It was then decided that the state could "delegate" its mission of national solidarity to the statutory AM, and henceforth pay only a lump sum for each affiliated CMU beneficiary, instead of the full expenditure (Frotiée, 2008: 14). The statutory AM was thus aligned with the private AMC. Will this precedent open new windows for future AM reforms in France?

The indirect cost of the new legislation was considerable in terms of work force, job training, and creative institutional renewal. The local AM funds had to learn how to handle income testing and coordination with other social administrations, in particular tax offices, labor offices and the many AMCs. According to the first Evaluation Report of the CMU Fund set up specifically for this purpose, the AM administration created 1,930 new stable positions (life employment) and in addition concluded 973 work contracts for limited periods (CMU Fonds, 2001: 3). With new rules and high public expectations, litigation also multiplied, especially during the first year. In 2000, the commissions for arbitration processed 38,000 CMU-related cases, nearly all of which contested the level of income[18]. Whilst most of the complaints were dismissed, at local or national level, the huge work of inquiry set a case precedent, especially for income testing that constituted a major innovation in the French social security system. The government provided only general guidelines to the executives of the new system: remain flexible to avoid public anger, but keep thresholds modest to avoid exploding public budgets (CMU Fonds, 2001: 4-5).

III Beneficiaries, Expenditure and Funding

To organize, steer and manage the CMU system, the 1999 Law set up a new public agency, the CMU Fund *(Fonds de Financement de la Protection Complémentaire de la Couverture Universelle du Risque Maladie)*. The Fund organized the implementation of the law, and since then has had the task of monitoring the situation, writing detailed annual evaluation reports[19], and making policy recommendations to the government and the social security institutions. Its main mission is to organize the financing of the CMU system. It collects the resources attributed to the system and allocates money to the institutions according to their number of affiliated CMU beneficiaries.

Up to 2012, the Fund allocated to the affiliating bodies an annual per capita lump sum of €370. This did not cover the real costs, which averaged €440 per beneficiary in 2013 (for CMU-C beneficiaries affiliated with the statutory AM; the only figures known). The 2013 law for financing the social security system fixed the annual lump sum at €400, but changed the rules to promote cost containment: the relevant institutions, both AM and AMC, are now reimbursed up to their real annual expenditure, but only within the limit of €408 (figure for 2014).

The source of financing has evolved considerably. Initially the government provided the funds, together with a limited voluntary participation of all AMCs. Following an agreement negotiated between the government and the national federation of the AMCs, the latter participated with a "solidarity contribution" then fixed at 1.75% of their general turnover. The rate was raised twice: to 2.5% in 2006, and to 5.9% in 2009. A major change occurred in 2011 when the annual law for the financing of the social security transformed the contribution into a "tax", labeled "Tax for Additional Solidarity" (*Taxe de solidarity additionnelle*). The rate was set at 6.27% of the insurer's turnover, payable by all AMCs, including those who did not have CMU-C affiliates or did not participate in the scheme. This changed the rules of the game, since a tax is not negotiable but compulsory. The tax has to be paid to the office that collects business taxes, which transmits it to the CMU Fund. The AMCs protested, especially the mutualist AMCs, arguing that they had a private and only voluntary membership, but the government stood firm.

As a result, the CMU safety net is not financed by general taxes, as such residency-based public safety nets usually are, but almost exclusively by the private AMCs. The latter integrate the cost increase into the price of their premiums, thus transferring the charge of a "national solidarity task" to their privately paying affiliates. The public input is limited to the recently decided attribution of a small part (3.15%) of the tobacco tax.

Although it is difficult to know the precise expenditure for the safety net[20], the total expenditure can be estimated at around three billion Euros per annum. In addition to the financial transfers operated by the CMU Fund (2,097 million Euros), the AME for undocumented residents represents €712 million, and public subsidies to medical humanitarian non-profit associations another €100 million. Furthermore, an unknown but non-negligible part of the 100% reimbursement within the ALD scheme (serious and long-term illnesses)[21] should be added because the ALD is sometimes used as a way to free patients from out-of-pocket charges, as a social arrangement between the care providers and their patients.

Table 3: Financial balance of the National CMU Fund, 2013

Expenditure:	**in million €**	**Receipts:**	**in million €**
Payments to the statutory AM for CMU-beneficiaries *	1,581	Solidarity Tax paid by the private complementary health insurance funds	2,066
Payments to the private AMC for CMU-beneficiaries **	264	Part of the Tobacco Tax transferred by the government	352
Payments to AMC to compensate for "ACS" ***	234	Unused service provisions	16
Service provisions	17		
Administration	1		
Total expenditure	**2,097**	**Total receipts**	**2,434**
Final result:		**Surplus, for reserves**	**+ 337**

Sources: Zaidman et al. (2014: 95), CMU Fund statistics for 2013

* Transfers to the public AM: up to €440 maximum per CMU-C beneficiary.

** Transfers to the private AMCs: up to €370 per beneficiary.

*** Transfers to the private AMCs to compensate for their ACS expenditure on beneficiaries.

Table 4: Estimation of the total cost of the safety net for health, 2013

Destination of expenditure	**In million €**	**Financed by:**
Basic and Complementary CMU, and ACS (Health voucher)	2,097	Total charges of the CMU Fund (tax on private AMC)
AME	712	State (central government)
Total for the compulsory schemes:	2,809	
Public subsidies to private action	100	Humanitarian organizations (central and local government)
Total expenditure	**2,909**	

Source: Author's own calculation, on the bases of the figures of official reports on the CMU (CMU Fonds, 2013b) and Zaidman et al. (2014: 90-95).

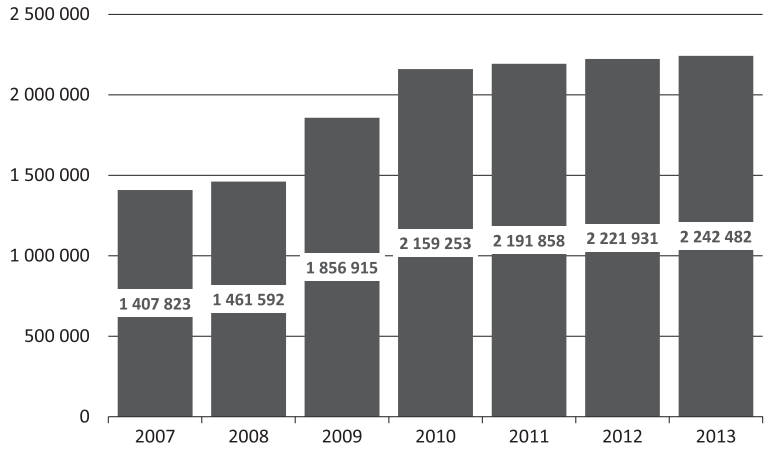

Figure 1: Number of beneficiaries of CMU-B, 2007-2013

Source: Statistics of the CMU Fund (www.cmu.fr)

Figure 1 shows the sudden growth in the number of beneficiaries, since 2008 and 2009. This can be interpreted as a direct effect of the financial crises and the economic slow-down causing more unemployment. Since the beginning of the CMU scheme, the number of beneficiaries reflects exactly the evolution of unemployment, including geographical distribution (CMU Fonds 2013b: 35).

Table 5: Beneficiaries of CMU-B

France	Metropolitan France		Overseas Territories		Total	
	Number	% of pop*	Number	% of pop*	Number	% of pop*
2007	1,146,748	1.8	261,075	14.3	1,407,823	2.2
2008	1,195,541	1.9	266,051	14.4	1,461,592	2.2
2009	1,554,821	2.4	302,094	16.2	1,856,915	2.8
2010	1,848,554	2.9	310,699	16.6	2,159,253	3.3
2011	1,877,343	2.9	314,515	16.7	2,191,858	3.3
2012	1,878,274	2.9	343,657	18.2	2,221,931	3.3
2013	1,898,330	2.9	344,152	18.2	2,242,482	3.4

Source: Statistics of the CMU Fund
* Percentage of the total population

Table 6: Beneficiaries of CMU-C

France	Metropolitan		Overseas		Total	
	Number	% of pop*	Number	% of pop*	Number	% of pop*
2007	3,808,644	6.0	589,415	32.2	4,398,063	6.8
2008	3,632,406	5.7	574,488	31.0	4,206,894	6.4
2009	3,577,406	5.6	577,244	31.0	4,154,665	6.3
2010	3,637,234	5.7	566,477	30.3	4,203,711	6.4
2011	3,754,887	5.8	560,703	29.7	4,315,590	6.5
2012	3,857,456	6.0	559,192	29.6	4,416,648	6.7
2013	4,057,196	6.3	566,173	30.0	4,623,369	7.0
2014 first estimation					5,125,000	7.7

Source: Statistics of the CMU Fund
* Percentage of the total population

Table 7: Beneficiaries of the "Health Voucher"

Over the last 12 months	Total number	% of total population
On 1 January 2010	597,892	0.90
Idem 2011	634,620	0.96
Idem 2012	784,575	1.19
Idem 2013	1,014,209	1.54
Idem 2014	1,160,863	1.76
1 June 2014, latest available	1,173,339	1.78

Source: Statistics of the CMU Fonds

The number of beneficiaries evolves differently, depending on the scheme. It tends to reflect the economic situation as well as the threshold effects resulting from policy decisions. Whilst the population covered by the CMU-B has grown slowly but steadily, the number of beneficiaries of the CMU-C remained at nearly the same level between 2007 and 2012, and even declined in 2008 and 2009, reflecting unchanged thresholds. It consequently increased immediately when the socialists returned to power and raised the thresholds. This effect is even stronger for the ACS beneficiaries, which exceeded the symbolic level of one million beneficiaries in 2013. The number of beneficiaries of the CMU-linked schemes, including AME, is estimated at more than 8 million people, i.e. approximately 12.5% of the population[22].

Detailed analysis shows that the CMU arrangements benefit mainly young people, who are most heavily hit by unemployment in France. The majority are women. The geographical distribution shows a strong concentration in the French Oversea Territories, where CMU and AME beneficiaries account for up to 30% of the population, followed by underprivileged suburban areas surrounding big cities, especially Paris (13%), and the most de-industrialized regions (Nord and Mediterranean coast, where the rate is 10 to 12 %). The geographic distribution of the medical safety net is similar to that of the minimum income, which suggests that the medical safety net spreads where it is economically most needed.

The AME beneficiaries constitute the main subject of public controversy around the medical safety net. Their evolution in numbers reflects politics, in which immigration is one of the main subjects of electoral debate. This explains the restrictions introduced in 2011, and their immediate abolition after the 2012 presidential election, when power passed from the Right to the Left:

- an annual flat rate of €30 to be paid per adult beneficiary,
- the prior authorization of the AM for any hospital inpatient treatment,
- the restriction of entitled family members to only (one) spouse and own children, excluding ascendants and siblings.

The AME has the same thresholds as the CMU, and allows access to all necessary care without payment. Furthermore, it includes several items of self-medication, but excludes thermal cures and artificial insemination.

The number of AME beneficiaries was 284,000 in 2013. After a steady growth rate of 5.4% per year during the period from 2007 to 2010, the number suddenly declined by 8.4% in 2011, a pre-electoral year under President Sarkozy (right wing). With the arrival of the socialist President Hollande, the number jumped up immediately, by 20% in 2012, and by another 12% in 2013 (Zaidman et al., 2014: 90).

Two problems regularly trigger controversy and a quest for better means of control – generally without any noteworthy success. First, it is very difficult to identify the real income of illegal immigrants, and equally difficult to identify the exact family relationships, especially with migrants from countries with weak administrative systems, a common situation in Africa from which many migrants to France come. Second, the 2007 report of the Social Affairs Inspection Board on the AME regime found major abuse, and regretted that prosecution for fraud was rare, even when it was clearly identified (IGF/IGAS, 2007). Collaboration between the Police and the AM started, for the first time, after this report.

A tricky everyday problem is that of asylum candidates, whose residency in the country is legal as long as no negative decision has been made. They thus qualify for the CMU scheme immediately on arrival. The AM administration however has difficulties distinguishing asylum candidates from illegal migrants and tries to orient them, often wrongly, towards the AME scheme. A new and growing problem is to identify care seekers who use the asylum window to benefit from legally provided free medical care for severe illness and urgency, before a final negative decision is taken on their asylum demand, which may take several months or a year. These cases illustrate the many practical difficulties in managing a coherent safety net that includes all residents, legal and illegal alike.

IV Assessing the French healthcare safety net

Despite intellectual criticism and practical shortcomings, the CMU is unquestionably a success story. It has organized a unified national and legitimate safety net that is more comprehensive and efficient than the previous local ones. As it is integrated into the common health insurance regime, it entitles beneficiaries to use the same care institutions and care baskets as the average contribution-paying patient. This normalization limits stigmatization, and transforms medical assistance into a legal right for full AM coverage. It also guarantees the quality of care delivered to the economically more underprivileged population.

The comprehensive assessment of policy outcomes, including contradictory results, is a delicate task. In this empirical case, the framework developed by Bovens, 't Hart and Peters for analyzing "success and failure in public governance" (2001), and the concept of "institutional fit" borrowed from EU studies (Guiliani, 2003) provide useful tools. These theoretical tools allow precise assessment by distinguishing three closely interwoven levels: programmatic, institutional and political.

Programmatic success and failure

In France the major obstacle to equal access to care is the incomplete reimbursement by the statutory AM, which makes it necessary to subscribe to an AMC. Therefore, an effective safety net must necessarily respond to this particular problem, as reports regularly point out (Jusot 2014). The CMU scheme focuses directly on this problem. According to the IRDES study (2010), only 4% of the general population still has no complementary health insurance. Among these people that are not covered by an AMC and not eligible for the CMU scheme, less then 43% claim that they cannot afford an AMC, which represents less than 1.7% of the country's population. The others state that they do not need one because they are already fully covered, either by the ALD scheme or as a family member, or do not wish to have one, or lack information. Given the comparatively young average age of this population without AMC coverage (29 years old, compared to an overall average age of 41), one may suppose they enjoy rather satisfactory health conditions and consequently have relatively little need for medical treatment. The main question then is whether the CMU reaches its specific target population, the poorest part of the population, when medical care is needed. The scheme is closely monitored, but two comprehensive indicators suffice to answer the question. One indicator is the socioeconomic distribution of the CMU-C. It shows two categories that together compose more than three quarters of all beneficiaries: "having never worked", and "unqualified workers". The CMU thus meets its target population. The second indicator is the comparative percentage of people who say that, for financial reasons, they have not sought healthcare at least once during the past year. This does not differ much between CMU-C beneficiaries and the general population with a private AMC: only 6% less for CMU-C

beneficiaries (Desprès et al. 2011: 2). This suggests that the reasons for not seeing a doctor are not specifically linked to CMU shortcomings.

Results concerning the 'health voucher' (ACS) show a more complex picture. In 2011, 78% of the potentially entitled ACS beneficiaries did not bother to apply for it (CMU Fonds 2013a; Guthmuller et al 2013). The high level of non-take-up suggests failure of the scheme to meet its goals. In order to identify the reasons, in-depth studies were conducted in Northern France over several years, including practical experimentation offering a higher subsidy, and improving information by inviting potential beneficiaries personally to briefing sessions (Guthmuller et al. 2014, 2011, 2010). The first tests showed that the higher sum of money offered improved the level of take-up only slightly; a better result, although still modest, was obtained with a more effective strategy of information and communication.

The studies revealed that many potential beneficiaries consider the administrative procedure as too complex to deal with, and too heavy compared to the expected advantage. Difficulties to understand administrative and practical problems, such as opening hours or transportation, have been identified as main reason for not applying for the ACS. One may conclude from this that the ACS scheme is not adapted to the most disadvantaged part of its target population, or inversely that the healthcare sector alone cannot correct the cumulated effects of general social inequality and weak inclusion.

Meanwhile, the amount of the subsidy has been increased. Information gaps and administrative problems have been identified and are currently being addressed. A precise gap has been identified since 2009, when the minimum income scheme was reformed. Before the reform, affiliation to the CMU used to be automatic for beneficiaries of the original minimum income allowance, without them having to follow any procedure. By contrast, the reformed version (*Revenu de Solidarité Active*), which entitles beneficiaries to the public allocation in addition to a limited amount of work income, now obliges potential beneficiaries to declare their income to the AM, and thus to take a positive action to initiate their affiliation to the CMU or ACS. In its 2013 report, the CMU Fund recommends closer institutional collaboration between the AM and the employment agencies, in order to close this gap (CMU Fonds 2013b). It proposes an obligation for the local employment agencies to systematically inform their clients about the change in the procedure, and furthermore an automatic electronic transmission of the relevant data. Such data connection between institutions has however encountered significant public and political opposition in France.

Despite these ongoing problems, the CMU seems to reach its programmatic targets, within the limits of the healthcare sector, without being able to solve all general problems such as weak administrative coordination, illiteracy, social exclusion, or cultural limits to the connection of data systems.

Institutional coherence

The question here is how the CMU scheme fits in with other institutional structures and principles. CMU thresholds remain very low, beneath the other social minima. This, the main shortcoming of the scheme, is an explicit policy choice linked to public cost containment. The AM has been cumulating deficits for two decades. Today it has become the main driver of the social security deficit, ahead of retirement pensions[23]. One may consider that low thresholds are a failure, but equally that the CMU stands out as a success in a context where the national public debt exceeds the agreed European Union levels.

The CMU fits the institutional organization and power structures of the French healthcare system. This has made the scheme workable, but also explains its limits. As doctors are not allowed to overcharge CMU and AME patients, many try to keep them away from their practice. Contracts held by ACS beneficiaries are generally of the cheapest category, and exclude the reimbursement of overcharged medical fees. The promised free choice of doctors is in reality limited for CMU beneficiaries. The CMU cannot remove the privileges of private medical practice, such as fee-for-service and overcharging, but it does promote the third-party-payer systems for CMU and AME beneficiaries. Studies show that half of the reimbursements paid out by private complementary health insurance companies, that is, for contribution-paying members, concern ambulatory care of private doctors and dentists, followed by non-vital medicines (Le Garrec et Bouvet 2013:194). This pattern contrasts with the predominant use of the emergency department of public hospitals by safety-net beneficiaries.

The key institutional fit of the CMU is its provision of complementary health insurance. This takes away the need for a major reform, which would be necessary if full reimbursement was to be granted by the statutory AM. Instead the CMU shifts the additional expenditure for the safety net to the contributing affiliates of the private AMC. The residency-based safety net does not invalidate the employment-based statutory AM. Residency as a criterion for affiliation is only subsidiary in France, that is, limited to the CMU. Furthermore, the public CMU does not contradict the dual architecture of the care offer, composed of a public hospital service and *médecine libérale.*

Political success and failure

Public opinion and all the French political parties support the CMU system. It is only now, with the effective reduction of public spending, that criticism is arising around the idea that CMU beneficiaries "get more" than those who work and pay contributions to the AM. The key point of controversy however is limited to a marginal but highly symbolic part of the system and the costs: the inclusion of illegal migrants, that is, the AME scheme, and the related difficulty to control benefits and prevent abuse. The subject continues to fuel electoral debate. This is harmful both to the beneficiaries and to the development of the CMU/AME system. The controversy will grow however with the massive arrival of migrants and refugees in Europe.

To sum it up, there is sufficient evidence to support the argument of success. On the programmatic level, the safety net is reaching those for whom it was designed. On the political level, public opinion and official reports continue to approve the scheme. On the institutional level, the CMU followed a complex public-private mix, in line with the architecture of the French healthcare and health insurance systems. The fact that general features of the healthcare sector and a rather high level of social inequality, in general, limit equal access to healthcare, and that electoral debate spreads into the health sector, does not mean a failure for the CMU. The CMU has been relatively successful in problem-identification, policy-making and implementation. The failures are spillovers from general national politics. The CMU responds to a social need, and rests on a more general policy of securing basic rights for poor people.

Three lessons can be learned from the French CMU case.

- First, the CMU is one of the rare examples where full rights have been formally integrated into a

social assistance program (Lafore 2008). The case indicates that the boundary between social assistance and social security can become blurred, despite current international trends towards a deepening separation.

- Second, the CMU shows how reform-resistant healthcare systems, such as the French one, can adapt to new needs and conditions. The process of change is incremental, bottom-up and pragmatic in terms of public expenditure.
- Third, the CMU may be more than just a medical safety net. It is part of a "new generation of social rights" (Gazier, Palier et Périvier 2014), responding to a socioeconomic evolution characterized by more unstable jobs, working poor, and youth unemployment. In this context, it provides an example of how a social health insurance system and centralized state regulation can interact to secure universal access to health insurance and care.

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Notes

1 This "general social contribution" (CSG – *Contribution sociale généralisée*) was first introduced in the mid-80s as a small complementary contribution on all non-work-related income, and was then gradually extended. A 1996 reform replaced the work-related contribution fully by a "general" social contribution on *all* income, including social benefits, interest from capital, rent from assets, etc.

2 Figure for 2010, the latest available: http://www.irdes.fr/EspaceEnseignement/ChiffresGraphiques/CouvertureComplementaire/DonneesGnles.html (consulted 10.02.2015)

3 Although to a lesser degree today, this "social diversion" of a medical regime has constituted a top priority for cost control since the 2000s. The attribution of the ALD benefit is now closely controlled by the National Fund of the AM, and by the High Health Authority (HAS – *Haute Autorité de Santé*).

4 The number of ADL beneficiaries grew from 3.7 million in 1994 to 9.2 million in 2011, which represents nearly one seventh of the population.

5 For the sake of legibility, the French term and its acronym "CMU" will be translated throughout this article as "Universal Medical Coverage", although it is an arrangement that guarantees access to comprehensive health *insurance* coverage.

6 The biggest humanitarian organization, specialized in medical assistance and militancy, *Medécins du Monde,* has an annual budget of approximately 65 million Euros, of which 40% is public finance (subsidies, service contracts) and 60% private fund raising (street collection, campaigning for donations), (Maury, 2013: 252).

7 Given the difficulty of translating the names of institutions, I have opted here to use the original French abbreviations CMU and AME. The abbreviation CMU refers to the regime as a whole, comprising: the "basic" CMU (CMU-B) or the "complementary CMU" (CMU-C).

8 Whilst international literature on the CMU is rare, French literature on the subject is abundant. In addition to the publications quoted in this paragraph, cf. Frotiée 2004, 2006, 2008; Borgetto, 2000; Lafore, 2008; Kerleau, 2012.

9 In 2000 the World Health Organization (WHO) rated the French system as offering "the best overall healthcare", as regards waiting lists and universal equal access (WHO, 2000).

10 The French *total* health expenditure is much higher: 250 billion Euros, nearly 12% of the GDP (2013). "Medical Consumption" *(Biens et Services Médicaux)* is the smallest statistical category used in French health statistics: it counts the expenditure for medical care and prevention devoted to the individual patient, excluding pay for sickness leave, long-term care, administration, research, training, and investment. Furthermore, the way to calculate the GDP was revised in 2010: with the former calculation, the medical consumption would be +0.3% higher, amounting to 9.1% of GDP in 2013 (instead of the 8.8% mentioned above).

11 This is the famous 1893 Law creating the *"Aide Médicale Gratuite"* for *"indigents"*. For details see: Renard 1995.

12 The term "income testing" is used in this article, since only income is considered for the admission to the CMU, not assets.

13 The information used here and in the following pages is taken from the original French official documents: the legal texts, the reports and statistics of the health ministry, the IRDES *(Institut de Recherche et de Documentation en Economie de la Santé)*, the *Cour des Comptes,* the inspection board for social affairs IGASS *(Inspection Générale des Affaires Sociales)*, the CNAM *(Caisse Nationale de l'Assurance Maladie)* which is the AM national fund, and the CMU Fund, especially its Annual Evaluation Reports (available via the Fund's website: www.cmu.fr).

14 All income is taken into account, of all the members of the household: income from work and capital, social benefits, pensions, and furthermore rent-free housing and any other free commodity.

15 The "three-month" delay aims at preventing abuse through "care-immigration". The limit was fixed in accordance with the limits of visa regulations (especially concerning family visits). Militant associations continue to fiercely criticize this delay, on grounds of medical urgency. In practice, in cases of emergency the necessary care will still be delivered, authorized on a case by case basis.

16 The initial 2004 project of the (right wing) government was to increase the CMU-threshold by 10%. The first draft of the 2004 bill specified +16%, and the final version voted by Parliament was +20%. This illustrates the low level of the threshold, and the still high public sensitivity for more solidarity when illness is concerned (Guthmuller et al., 2010: 5).

17 An electoral promise of President Holland, implemented immediately after his election. The government's plan to extend this to 44.5% has so far not been implemented because of the high level of public debt.

18 Of these 38,000 complaints, in 12,000 cases the decision was revised by the local commissions, and 260 were judged after appeal at the national level, of which 60 received a revised decision in favor of the plaintiff (CMU Fonds, Evaluation Report 2001: 4–5).

19 The Fund's reports provided most valuable information for this article (reports available at www.cum.fr).

20 It is impossible to isolate the real costs for medical care of CMU beneficiaries within the accountancy system of the private AMC (CMU Fonds, 2013b)

21 In 2009, the ALD concerned 15% of the affiliated members of the statutory AM: 8.6 million people, consuming nearly 60% of the expenditure of the AM (Dourgnon, Or, et Sorasit 2013: 1–2). The number of ALD beneficiaries had grown to 9.2 million in 2011.

22 The National Fund of the AM (CNAM) indicates (website: www.ameli.fr) that double counting is possible, between the CMU-B and -C, for probably 1.5 million beneficiaries. It estimates the corrected number of both at 5.8 million beneficiaries. That is together with ACS and AME beneficiaries 11.9% of population.

23 The deficit of the statutory HI amounted to 6.8 billion Euros in 2013, compared to the deficit of 3.1 billion for the statutory pension fund. The deficit of the HI is expected to grow fast: to 7.3 billion in 2014 and 10.5 billion in 2015, against an improvement of the deficit of the pension fund (-1.6 and -1.4 billion respectively) (Commission des Comptes de la Sécurité sociale, 2014:12, 17–19)

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普遍主義と私的財源
―普遍医療給付のフランス・モデル―

モニカ・ステフェン[i]

1999年の法改正によりフランスでは，貧困者に対するさまざまな医療扶助が刷新され統合された。この法により法定健康保険制度に無料で加入が行われるようになるとともに，無料あるいは補助金を受け取って補完健康保険制度に加入することが可能となった。つまり，無所得ないし低所得の人々は無料の医療アクセスを手に入れたのである。新しい制度は，医療機構についての理論的検討では対立する要素と考えられているもの，つまり普遍主義，選択，所得制限，を組み合わせたものである。このフランス独特のやり方は，貧困からの救済と公費支出の管理という二つの政策の潮流の妥協によって生まれている。結果として，特定の税を介し，私的な補完保険の資金によって賄われる統一された公的セイフティ・ネットとなった。本論文は，まず制度的な文脈と関連する理論上の論争を概観する。次に政策形成の過程を分析し，普遍的な医療給付の編制（CMU-Couverture Maladie Universelle）を記述する。3つめの部分では，受給者，財政，支出に焦点をあてる。4つめの最後の部分では，改革結果の成否を検討する。そこでは，緩やかな所得制限があるとはいえ医療セイフティ・ネットが実質的に改善したこと，滞在資格を持たない移民については今もなお議論があるものの，この法制を支持する広範な政治的コンセンサスが生じたこと，そして社会扶助を法的権利とする制度上の通常化が生じたこと，が述べられる[1)]。

キーワード：医療セイフティ・ネット，普遍医療給付，普遍医療給付制度（CMU），滞在資格を持たない移民，フランス

1）本抄録の翻訳は松田亮三（立命館大学・産業社会学部）が行った。なるべく読みやすい日本語となるよう一部意訳してあることをお断りしておく。

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